AUSTRALASIAN COLLEGE OF
SPORT AND EXERCISE PHYSICIANS

TP3.3

Case-Based Discussion (CbD) Form

DESCRIPTION

CbD assesses the performance of a Registrar in managing a patient. This assessment gives an indication of competence regarding clinical reasoning in relation to decisions made about a patient's assessment, investigation, treatment, referral and follow up.

SECTION 1 – REGISTRAR DETAILS

Registrar name					
Stage of training		Training Period		Year	
EPA					
CbD description					
Problem complexity		Setting			
Patient gender		Patient age		Patient ethnicity	

SECTION 2 – WBA RATING

OVERALL RATING

The Registrar required:

- ◯ **Significant proactive input** in relation to aspects of the case.
- ◯ **Some prompting** in relation to aspects of the case.
- ◯ **Minimal guidance**. I provided some suggestions which would have improved the management of the case.
- ◯ **No guidance**. They provided effective patient care and would have reached out for assistance for a more complex case.
- ◯ **The Registrar could advise junior colleagues how to manage similar patients.**

The Assessor should provide feedback, in the form of comments, on the Registrar's performance on the following. If not applicable to this particular assessment, note 'N/A'.

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Patient assessment: Presents relevant details of the history, demonstrates the patient's story was understood; performed a physical examination appropriate to the problem.
Selection and interpretation of investigations: Can discuss the rationale for investigations ordered/performed; considered risks/benefits to patient; demonstrates awareness of sensitivity and specificity of investigations; interprets findings accurately.
Management plan: Provides rationale for evidence-based management plan, including risks and benefits to patient; patient context and preferences taken into account.
Response to alternate scenarios: Responds to possible patient scenarios with appropriate changes to management plan.
Reflection: Considers outcomes for patient and identifies how management could be improved for a similar case in the future.

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Clinical record keeping and letters: Record is legible, signed dated and appropriate to problem; record is understandable in relation to and in sequence with other entries (including for the next clinician to provide care); referrals or letters back to referring practitioner provide sufficient detail and written appropriately for audience.

SIGNOFF

Assessor Name		Position	
Assessor Signature		Date	
Registrar Signature		Date	